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I

106TH CONGRESS
2D SESSION

H. R. 3887

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MARCH 9, 2000

Mr. LEVIN (for himself, Mr. FOLEY, Mr. PALLONE, Mr. LEACH, Mr. MORAN of Virginia, Mr. BONIOR, and Ms. BERKLEY) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To promote primary and secondary health promotion and disease prevention services and activities among the elderly, to amend title XVIII of the Social Security Act to add preventive benefits, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare Wellness Act of 2000”.

- 1 (b) TABLE OF CONTENTS.—The table of contents is
 2 as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Finding.

Sec. 3. Definitions.

TITLE I—HEALTHY SENIORS PROMOTION PROGRAM

Sec. 101. Healthy Seniors Promotion Program.

Sec. 102. Sense of Congress regarding the response of HCFA to preventive health issues.

Sec. 103. Sense of Congress regarding the efforts of HCFA to study health promotion and disease prevention for medicare beneficiaries.

Sec. 104. Sense of Congress regarding the establishment of a medicare health promotion and disease prevention clearinghouse.

TITLE II—MEDICARE COVERAGE OF PREVENTIVE SERVICES

Sec. 201. Counseling for cessation of tobacco use.

Sec. 202. Screening for hypertension.

Sec. 203. Counseling for hormone replacement therapy.

Sec. 204. Screening for glaucoma.

Sec. 205. Screening for diminished visual acuity.

Sec. 206. Screening for hearing impairment.

Sec. 207. Screening and counseling for osteoporosis.

Sec. 208. Screening for cholesterol.

Sec. 209. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.

Sec. 210. Elimination of cost-sharing for current preventive benefits.

Sec. 211. National falls prevention education and awareness campaign.

Sec. 212. Program integrity.

TITLE III—MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

Sec. 301. Medicare Health Education and Risk Appraisal Program.

TITLE IV—DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS

Sec. 401. Disease self-management demonstration projects.

TITLE V—STUDIES AND REPORTS ADVANCING ORIGINAL RESEARCH IN THE FIELD OF DISEASE PREVENTION AND THE ELDERLY

Sec. 501. MedPAC biannual report.

Sec. 502. National Institute on Aging study and report.

Sec. 503. Institute of Medicine 5-year medicare prevention benefit study and report.

Sec. 504. Fast-track consideration of prevention benefit legislation.

TITLE VI—CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS

Sec. 601. Clinical depression screening demonstration projects.

1 **SEC. 2. FINDING.**

2 Congress finds that despite significant advancements
3 in general research for health promotion and disease pre-
4 vention among the elderly, there has been a failure in
5 translating that research into practical intervention.

6 **SEC. 3. DEFINITIONS.**

7 As used in this Act:

8 (1) **COST-EFFECTIVE BENEFIT.**—The term
9 “cost-effective benefit” means a benefit or technique
10 that has—

11 (A) been subject to peer review;

12 (B) been described in scientific journals;

13 and

14 (C) demonstrated value as measured by
15 unit costs relative to health outcomes achieved.

16 (2) **COST-SAVING BENEFIT.**—The term “cost-
17 saving benefit” means a benefit or technique that
18 has—

19 (A) been subject to peer review;

20 (B) been described in scientific journals;

21 and

22 (C) caused a net reduction in health care
23 costs for medicare beneficiaries.

24 (3) **MEDICALLY EFFECTIVE.**—The term “medi-
25 cally effective” means, with respect to a benefit or
26 technique, that the benefit or technique has been—

- 1 (A) subject to peer review;
2 (B) described in scientific journals; and
3 (C) determined to achieve an intended goal
4 under normal programmatic conditions.

5 (4) MEDICAL EFFICACY; MEDICALLY EFFICA-
6 CIOUS.—The terms “medical efficacy” and “medi-
7 cally efficacious” mean, with respect to a benefit or
8 technique, that the benefit or technique has been—

- 9 (A) subject to peer review;
10 (B) described in scientific journals; and
11 (C) determined to achieve an intended goal
12 under controlled conditions.

13 (5) MEDICARE BENEFICIARY.—The term
14 “medicare beneficiary” means any individual who is
15 entitled to benefits under part A or enrolled under
16 part B of the medicare program, including any indi-
17 vidual enrolled in a Medicare+Choice plan offered
18 by a Medicare+Choice organization under part C of
19 such program.

20 (6) MEDICARE PROGRAM.—The term “medicare
21 program” means the health benefits program under
22 title XVIII of the Social Security Act (42 U.S.C.
23 1395 et seq.).

24 (7) SECRETARY.—The term “Secretary” means
25 the Secretary of Health and Human Services.

TITLE I—HEALTHY SENIORS PROMOTION PROGRAM

SEC. 101. HEALTHY SENIORS PROMOTION PROGRAM.

(a) DEFINITIONS.—As used in this section:

(1) ELIGIBLE ENTITY.—The term “eligible entity” means an entity that the Working Group (as defined in paragraph (2)) determines has demonstrated expertise in research regarding health promotion and disease prevention among the elderly.

(2) WORKING GROUP.—The term “Working Group” means the Healthy Seniors Working Group established under subsection (d).

(b) PROGRAM AUTHORIZED.—The Secretary, subject to the general policies and criteria established by the Working Group and in accordance with the provisions of this Act, is authorized to make grants to eligible entities to pay for the costs of the activities described in subsection (c).

(c) USE OF FUNDS.—An eligible entity may use payments received under this section in any fiscal year to study—

(1) whether using different types of providers of care who are not physicians and alternative settings (including community-based senior centers) for the implementation of a successful health promotion and

disease prevention strategy, including the implications regarding the payment of such providers, is medically efficacious or medically effective;

(2) the most medically effective means of educating medicare beneficiaries and providers of services regarding the importance of health promotion and disease prevention among the elderly and identification of incentives that would increase the use of new and existing preventive services and healthy behaviors by medicare beneficiaries; and

(3) other topics designated by the Secretary.

(d) HEALTHY SENIORS WORKING GROUP.—

(1) ESTABLISHMENT.—There is established within the Department of Health and Human Services a Healthy Seniors Working Group.

(2) COMPOSITION.—Subject to paragraph (3), the Working Group established pursuant to subsection (b) shall be composed of 5 members as follows:

(A) The Administrator of the Health Care Financing Administration.

(B) The Director of the Centers for Disease Control and Prevention.

(C) The Administrator of the Agency for Health Care Policy and Research.

1 (D) The Assistant Secretary for Aging.

2 (E) The Director of the National Institute
3 on Aging.

4 (3) ALTERNATIVE MEMBERSHIP.—

5 (A) APPOINTMENT.—Any member of the
6 Working Group described in a subparagraph of
7 paragraph (2) may appoint an individual who is
8 an officer or employee of the Federal Govern-
9 ment to serve as a member of the Working
10 Group instead of the member described in such
11 subparagraph.

12 (B) DEADLINE.—If a member described in
13 subparagraph (A) elects to appoint an indi-
14 vidual under such subparagraph, such indi-
15 vidual shall be appointed not later than Decem-
16 ber 31, 2001.

17 (4) GENERAL POLICIES AND CRITERIA.—The
18 Working Group shall establish general policies and
19 criteria with respect to the functions of the Sec-
20 retary under this section including—

21 (A) priorities for the approval of applica-
22 tions submitted under subsection (e);

23 (B) procedures for developing, monitoring,
24 and evaluating research efforts conducted under
25 this section; and

1 (C) such other matters as are rec-
2 ommended by the Working Group and approved
3 by the Secretary.

4 (5) CHAIRPERSON.—The Chairperson of the
5 Working Group shall be the Administrator of the
6 Agency for Health Care Policy and Research.

7 (6) QUORUM.—A majority of the members of
8 the Working Group shall constitute a quorum, but
9 a lesser number of members may hold hearings.

10 (7) MEETINGS.—The Working Group shall
11 meet at the call of the Chairperson, except that—

12 (A) it shall meet not less than 4 times each
13 year; and

14 (B) it shall meet whenever a majority of
15 the appointed members request a meeting in
16 writing.

17 (8) COMPENSATION OF MEMBERS.—Each mem-
18 ber of the Working Group shall be an officer or em-
19 ployee of the Federal Government and shall serve
20 without compensation in addition to that received for
21 their service as an officer or employee of the Federal
22 Government.

23 (e) APPLICATION.—

24 (1) IN GENERAL.—Each eligible entity which
25 desires to receive a grant under this section shall

1 submit an application to the Secretary, at such time,
2 in such manner, and accompanied by such additional
3 information as the Secretary may reasonably re-
4 quire.

5 (2) CONTENTS.—Each application submitted
6 pursuant to paragraph (1) shall—

7 (A) describe the activities for which assist-
8 ance under this section is sought;

9 (B) describe how the research effort pro-
10 posed to be conducted will reflect the medical,
11 behavioral, and social aspects of care for the el-
12 derly, lead to the development of cost-effective
13 benefits and cost-saving benefits, and impact
14 the quality of life of medicare beneficiaries;

15 (C) provide evidence that the eligible entity
16 meets the general policies and criteria estab-
17 lished by the Working Group pursuant to sub-
18 section (d)(4);

19 (D) provide assurances that the eligible en-
20 tity will take such steps as may be available to
21 it to continue the activities for which the eligi-
22 ble entity is making application after the period
23 for which assistance is sought; and

24 (E) provide such additional assurances as
25 the Secretary determines to be essential to en-

1 sure compliance with the requirements of this
2 Act.

3 (3) JOINT APPLICATION.—A consortium of eli-
4 gible entities may file a joint application under the
5 provisions of paragraph (1) of this subsection.

6 (f) APPROVAL OF APPLICATION.—The Secretary
7 shall approve applications in accordance with the general
8 policies and criteria established by the Working Group
9 under subsection (d)(4).

10 (g) PAYMENTS.—The Secretary shall pay to each eli-
11 gible entity having an application approved under sub-
12 section (f) the cost of the activities described in the appli-
13 cation.

14 (h) EVALUATION AND REPORT.—

15 (1) EVALUATION.—The Secretary shall conduct
16 an annual evaluation of grants made under this sec-
17 tion to determine—

18 (A) the results of the overall applied re-
19 search conducted under this Act;

20 (B) the extent to which research assisted
21 under this section has improved or expanded
22 the general research for health promotion and
23 disease prevention among the elderly and identi-
24 fied practical interventions based upon such re-
25 search;

1 (C) a list of specific recommendations
2 based upon research conducted under this sec-
3 tion which show promise as practical interven-
4 tions for health promotion and disease preven-
5 tion among the elderly;

6 (D) whether or not as a result of the ap-
7 plied research effort certain health promotion
8 and disease prevention benefits or education ef-
9 forts should be added to the medicare program,
10 including discussions of quality of life, trans-
11 lating the applied research results into a benefit
12 under the medicare program, and whether each
13 additional benefit would be a cost-effective ben-
14 efit or a cost-saving benefit for each proposed
15 addition;

16 (E) the utility of, potential for, and issues
17 surrounding health risk appraisals sponsored
18 under the medicare program and targeted fol-
19 lowup; and

20 (F) how best to increase utilization of ex-
21 isting and recommended health promotion and
22 disease prevention services, including an edu-
23 cation and public awareness component discus-
24 sion of financial incentives for providers of serv-
25 ices and medicare beneficiaries to improve utili-

1 zation and other administrative means of in-
2 creasing utilization.

3 (2) ANNUAL REPORT.—Not later than Decem-
4 ber 31, 2002, and each year thereafter through
5 2005, the Secretary shall submit a report to Con-
6 gress based on the annual studies made under para-
7 graph (1), which shall contain a detailed statement
8 of the findings and conclusions of the Working
9 Group together with its recommendations for such
10 legislation and administrative actions as it considers
11 appropriate.

12 (i) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated \$40,000,000 for each
14 of the fiscal years 2001, 2002, 2003, and 2004 to carry
15 out the provisions of this section.

16 **SEC. 102. SENSE OF CONGRESS REGARDING THE RESPONSE**
17 **OF HCFA TO PREVENTIVE HEALTH ISSUES.**

18 It is the sense of Congress that in administering the
19 medicare program the Secretary should ensure that the
20 Administrator of the Health Care Financing Administra-
21 tion encourages the inclusion of preventive measures as
22 part of all treatments described in such program.

1 **SEC. 103. SENSE OF CONGRESS REGARDING THE EFFORTS**
2 **OF HCFA TO STUDY HEALTH PROMOTION**
3 **AND DISEASE PREVENTION FOR MEDICARE**
4 **BENEFICIARIES.**

5 It is the sense of Congress that the Secretary should
6 ensure that the Administrator of the Health Care Financ-
7 ing Administration expands the study of the most prom-
8 ising behavioral modification of risk factors associated
9 with health promotion and disease prevention for all medi-
10 care beneficiaries.

11 **SEC. 104. SENSE OF CONGRESS REGARDING THE ESTAB-**
12 **LISHMENT OF A MEDICARE HEALTH PRO-**
13 **MOTION AND DISEASE PREVENTION CLEAR-**
14 **INGHOUSE.**

15 It is the sense of Congress that the National Library
16 of Medicine should collect information regarding innova-
17 tive and successful health promotion and disease preven-
18 tion interventions from both published and unpublished
19 sources, establish a clearinghouse targeting all medicare
20 beneficiaries in a variety of settings for the consolidation
21 and coordination of all such information, and make the
22 clearinghouse available to the public and accessible
23 through the Internet.

1 **TITLE II—MEDICARE COVERAGE**
2 **OF PREVENTIVE SERVICES**

3 **SEC. 201. COUNSELING FOR CESSATION OF TOBACCO USE.**

4 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
5 curity Act (42 U.S.C. 1395x(s)(2)) is amended—

6 (1) in subparagraph (S), by striking “and” at
7 the end;

8 (2) in subparagraph (T), by inserting “and” at
9 the end; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(U) counseling for cessation of tobacco use (as
13 defined in subsection (uu)) for individuals who have
14 a history of tobacco use;”.

15 (b) **SERVICES DESCRIBED.**—Section 1861 of such
16 Act (42 U.S.C. 1395x) is amended by adding at the end
17 the following new subsection:

18 “Counseling for Cessation of Tobacco Use

19 “(uu)(1) Except as provided in paragraph (2), the
20 term ‘counseling for cessation of tobacco use’ means diag-
21 nostic, therapy, and counseling services for cessation of
22 tobacco use which are furnished—

23 “(A) by or under the supervision of a physician;
24 or

“(B) by any other health care professional who is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished, as would otherwise be covered if furnished by a physician or as an incident to a physician’s professional service.

“(2) The term ‘counseling for cessation of tobacco use’ does not include coverage for drugs or biologicals that are not otherwise covered under this title.”.

(c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking “and” before “(S)”; and

(B) by inserting before the semicolon at the end the following: “, and (T) with respect to counseling for cessation of tobacco use (as defined in section 1861(uu)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph”.

1 (2) ELIMINATION OF DEDUCTIBLE.—The first
2 sentence of section 1833(b) of such Act (42 U.S.C.
3 1395l(b)) is amended—

4 (A) by striking “and” before “(6)”; and

5 (B) by inserting before the period the fol-
6 lowing: “, and (7) such deductible shall not
7 apply with respect to counseling for cessation of
8 tobacco use (as defined in section 1861(uu))”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to services furnished on or after
11 January 1, 2002.

12 **SEC. 202. SCREENING FOR HYPERTENSION.**

13 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
14 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
15 tion 201(a)) is amended—

16 (1) in subparagraph (T), by striking “and” at
17 the end;

18 (2) in subparagraph (U), by inserting “and” at
19 the end; and

20 (3) by adding at the end the following new sub-
21 paragraph:

22 “(V) screening for hypertension (as defined in
23 subsection (vv)) not more frequently than once every
24 2 years for individuals with normotensive blood pres-
25 sure measurements and annually for individuals with

1 blood pressure measurements that are not
2 normotensive;”.

3 (b) SERVICES DESCRIBED.—Section 1861 of such
4 Act (42 U.S.C. 1395x) (as amended by section 201(b))
5 is amended by adding at the end the following new sub-
6 section:

7 “Screening for Hypertension

8 “(vv) The term ‘screening for hypertension’ means di-
9 agnostic services for hypertension which are furnished—

10 “(1) by or under the supervision of a physician;
11 or

12 “(2) by any other health care professional who
13 is legally authorized to furnish such services under
14 State law (or the State regulatory mechanism pro-
15 vided by State law) of the State in which the serv-
16 ices are furnished, as would otherwise be covered if
17 furnished by a physician or as an incident to a phy-
18 sician’s professional service.”.

19 (c) ELIMINATION OF COST-SHARING.—

20 (1) ELIMINATION OF COINSURANCE.—Section
21 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
22 amended by section 201(c)(1)) is amended—

23 (A) by striking “and” before “(T)”; and

24 (B) by inserting before the semicolon at
25 the end the following: “, and (U) with respect

1 to screening for hypertension (as defined in sec-
2 tion 1861(vv)), the amount paid shall be 100
3 percent of the lesser of the actual charge for
4 the services or the amount determined by a fee
5 schedule established by the Secretary for the
6 purposes of this subparagraph;”.

7 (2) ELIMINATION OF DEDUCTIBLE.—The first
8 sentence of section 1833(b) of such Act (42 U.S.C.
9 1395l(b)) (as amended by section 201(c)(2)) is
10 amended—

11 (A) by striking “and” before “(7)”; and

12 (B) by inserting before the period the fol-
13 lowing: “, and (8) such deductible shall not
14 apply with respect to screening for hypertension
15 (as defined in section 1861(vv))”.

16 (d) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to services furnished on or after
18 January 1, 2002.

19 **SEC. 203. COUNSELING FOR HORMONE REPLACEMENT**
20 **THERAPY.**

21 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
22 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
23 tion 202(a)) is amended—

24 (1) in subparagraph (U), by striking “and” at
25 the end;

1 (2) in subparagraph (V), by inserting “and” at
2 the end; and

3 (3) by adding at the end the following new sub-
4 paragraph:

5 “(W) counseling for hormone replacement ther-
6 apy (as defined in subsection (ww));”.

7 (b) SERVICES DESCRIBED.—Section 1861 of such
8 Act (42 U.S.C. 1395x) (as amended by section 202(b))
9 is amended by adding at the end the following new sub-
10 section:

11 “Counseling for Hormone Replacement Therapy

12 “(ww)(1) Except as provided in paragraph (2), the
13 term ‘counseling for hormone replacement therapy’ means
14 diagnostic, therapy, and counseling services for hormone
15 replacement which are furnished—

16 “(A) by or under the supervision of a physician;
17 or

18 “(B) by any other health care professional who
19 is legally authorized to furnish such services under
20 State law (or the State regulatory mechanism pro-
21 vided by State law) of the State in which the serv-
22 ices are furnished, as would otherwise be covered if
23 furnished by a physician or as an incident to a phy-
24 sician’s professional service.

1 “(2) The term ‘counseling for hormone replacement
2 therapy’ does not include coverage for drugs or biologicals
3 that are not otherwise covered under this title.”.

4 (c) ELIMINATION OF COST-SHARING.—

5 (1) ELIMINATION OF COINSURANCE.—Section
6 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
7 amended by section 202(c)(1)) is amended—

8 (A) by striking “and” before “(U)”;

9 (B) by inserting before the semicolon at
10 the end the following: “, and (V) with respect
11 to counseling for hormone replacement therapy
12 (as defined in section 1861(w)), the amount
13 paid shall be 100 percent of the lesser of the
14 actual charge for the services or the amount de-
15 termined by a fee schedule established by the
16 Secretary for the purposes of this subpara-
17 graph;”.

18 (2) ELIMINATION OF DEDUCTIBLE.—The first
19 sentence of section 1833(b) of such Act (42 U.S.C.
20 1395l(b)) (as amended by section 202(c)(2)) is
21 amended—

22 (A) by striking “and” before “(8)”;

23 (B) by inserting before the period the fol-
24 lowing: “, and (9) such deductible shall not
25 apply with respect to counseling for hormone

1 replacement therapy (as defined in section
2 1861(ww))”.

3 (d) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to services furnished on or after
5 January 1, 2002.

6 **SEC. 204. SCREENING FOR GLAUCOMA.**

7 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
8 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
9 tion 203(a)) is amended—

10 (1) in subparagraph (V), by striking “and” at
11 the end;

12 (2) in subparagraph (W), by inserting “and” at
13 the end; and

14 (3) by adding at the end the following new sub-
15 paragraph:

16 “(X) screening for glaucoma (as defined in sub-
17 section (xx)) for individuals determined to be at high
18 risk for glaucoma, individuals with a family history
19 of glaucoma, and individuals with diabetes or myo-
20 pia;”.

21 (b) SERVICES DESCRIBED.—Section 1861 of such
22 Act (42 U.S.C. 1395x) (as amended by section 203(b))
23 is amended by adding at the end the following new sub-
24 section:

1 “Screening for Glaucoma

2 “(xx) The term ‘screening for glaucoma’ means a di-
 3 lated eye examination with an intraocular pressure meas-
 4 urement, and a direct ophthalmoscopy or a slit-lamp bio-
 5 microscopic examination for the early detection of glau-
 6 coma which is furnished by or under the supervision of
 7 an optometrist or ophthalmologist who is legally author-
 8 ized to furnish such services under State law (or the State
 9 regulatory mechanism provided by State law) of the State
 10 in which the services are furnished, as would otherwise
 11 be covered if furnished by a physician or as an incident
 12 to a physician’s professional service.”.

13 (c) ELIMINATION OF COST-SHARING.—

14 (1) ELIMINATION OF COINSURANCE.—Section
 15 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 16 amended by section 203(c)(1)) is amended—

17 (A) by striking “and” before “(V)”;

18 (B) by inserting before the semicolon at
 19 the end the following: “, and (W) with respect
 20 to screening for glaucoma (as defined in section
 21 1861(xx)), the amount paid shall be 100 per-
 22 cent of the lesser of the actual charge for the
 23 services or amount determined by a fee schedule
 24 established by the Secretary for the purposes of
 25 this subparagraph;”.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 203(c)(2)) is amended—

(A) by striking “and” before “(9)”; and

(B) by inserting before the period the following: “, and (10) such deductible shall not apply with respect to screening for glaucoma (as defined in section 1861(xx))”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

SEC. 205. SCREENING FOR DIMINISHED VISUAL ACUITY.

(a) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) (as amended by section 204(a)) is amended—

(1) in subparagraph (W), by striking “and” at the end;

(2) in subparagraph (X), by inserting “and” at the end; and

(3) by adding at the end the following new subparagraph:

“(Y) screening for diminished visual acuity (as defined in subsection (yy));”.

1 (b) SERVICES DESCRIBED.—Section 1861 of such
 2 Act (42 U.S.C. 1395x) (as amended by section 204(b))
 3 is amended by adding at the end the following new sub-
 4 section:

5 “Screening for Diminished Visual Acuity

6 “(yy) The term ‘screening for diminished visual acu-
 7 ity’ means diagnostic services for screening for diminished
 8 visual acuity which are furnished by or under the super-
 9 vision of an optometrist or ophthalmologist who is legally
 10 authorized to furnish such services under State law (or
 11 the State regulatory mechanism provided by State law) of
 12 the State in which the services are furnished, as would
 13 otherwise be covered if furnished by a physician or as an
 14 incident to a physician’s professional service.”.

15 (c) ELIMINATION OF COST-SHARING.—

16 (1) ELIMINATION OF COINSURANCE.—Section
 17 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
 18 amended by section 204(c)(1)) is amended—

19 (A) by striking “and” before “(W)”;

20 (B) by inserting before the semicolon at
 21 the end the following: “, and (X) with respect
 22 to screening for diminished visual acuity (as de-
 23 fined in section 1861(yy)), the amount paid
 24 shall be 100 percent of the lesser of the actual
 25 charge for the services or the amount deter-

1 mined by a fee schedule established by the Sec-
2 retary for the purposes of this subparagraph;”.

3 (2) ELIMINATION OF DEDUCTIBLE.—The first
4 sentence of section 1833(b) of such Act (42 U.S.C.
5 1395l(b)) (as amended by section 204(c)(2)) is
6 amended—

7 (A) by striking “and” before “(10)”; and

8 (B) by inserting before the period the fol-
9 lowing: “. and (11) such deductible shall not
10 apply with respect to screening for diminished
11 visual acuity (as defined in section 1861(yy))”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to services furnished on or after
14 January 1, 2002.

15 **SEC. 206. SCREENING FOR HEARING IMPAIRMENT.**

16 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
17 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
18 tion 205(a)) is amended—

19 (1) in subparagraph (X), by striking “and” at
20 the end;

21 (2) in subparagraph (Y), by inserting “and” at
22 the end; and

23 (3) by adding at the end the following new sub-
24 paragraph:

1 “(Z) screening for hearing impairment (as de-
2 fined in subsection (zz));”.

3 (b) SERVICES DESCRIBED.—Section 1861 of such
4 Act (42 U.S.C. 1395x) (as amended by section 205(b))
5 is amended by adding at the end the following new sub-
6 section:

7 “Screening for Hearing Impairment

8 “(zz) The term ‘screening for hearing impairment’
9 means diagnostic services for hearing impairment by use
10 of periodic questions, otoscopic examination and audio
11 metric testing if such questions indicate potential hearing
12 impairment, and counseling about hearing aid devices
13 which are furnished—

14 “(1) by or under the supervision of a physician;
15 or

16 “(2) by any other health care professional who
17 is legally authorized to furnish such services under
18 State law (or the State regulatory mechanism pro-
19 vided by State law) of the State in which the serv-
20 ices are furnished, as would otherwise be covered if
21 furnished by a physician or as an incident to a phy-
22 sician’s professional service.”.

23 (c) ELIMINATION OF COST-SHARING.—

(1) ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as amended by section 205(c)(1)) is amended—

(A) by striking “and” before “(X)”; and

(B) by inserting before the semicolon at the end the following: “, and (Y) with respect to screening for hearing impairment (as defined in section 1861(zz)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;”.

(2) ELIMINATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of such Act (42 U.S.C. 1395l(b)) (as amended by section 205(c)(2)) is amended—

(A) by striking “and” before “(11)”; and

(B) by inserting before the period the following: “, and (12) such deductible shall not apply with respect to screening for hearing impairment (as defined in section 1861(zz))”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2002.

1 **SEC. 207. SCREENING AND COUNSELING FOR**
2 **OSTEOPOROSIS.**

3 (a) **COVERAGE.**—Section 1861(s)(2) of the Social Se-
4 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
5 tion 206(a)) is amended—

6 (1) in subparagraph (Y), by striking “and” at
7 the end;

8 (2) in subparagraph (Z), by inserting “and” at
9 the end; and

10 (3) by adding at the end the following new sub-
11 paragraph:

12 “(AA) screening and counseling for osteoporosis
13 (as defined in subsection (aaa)) for—

14 “(i) women; and

15 “(ii) men with fractures;”.

16 (b) **SERVICES DESCRIBED.**—Section 1861 of such
17 Act (42 U.S.C. 1395x) (as amended by section 206(b))
18 is amended by adding at the end the following new sub-
19 section:

20 “Screening and Counseling for Osteoporosis

21 “(aaa) The term ‘screening and counseling for
22 osteoporosis’ means diagnostic and counseling services for
23 osteoporosis in addition to a bone mass measurement (as
24 defined in subsection (rr)) which are furnished in accord-
25 ance with methods approved by the Food and Drug
26 Administration—

1 “(1) by or under the supervision of a physician;
2 or

3 “(2) by any other health care professional who
4 is legally authorized to furnish such services under
5 State law (or the State regulatory mechanism pro-
6 vided by State law) of the State in which the serv-
7 ices are furnished, as would otherwise be covered if
8 furnished by a physician or as an incident to a phy-
9 sician’s professional service.”.

10 (c) ELIMINATION OF COST-SHARING.—

11 (1) ELIMINATION OF COINSURANCE.—Section
12 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
13 amended by section 206(c)(1)) is amended—

14 (A) by striking “and” before “(Y)”; and

15 (B) by inserting before the semicolon at
16 the end and inserting the following: “, and (Z)
17 with respect to screening and counseling for
18 osteoporosis (as defined in section 1861(aaa)),
19 the amount paid shall be 100 percent of the
20 lesser of the actual charge for the services or
21 the amount determined by a fee schedule estab-
22 lished by the Secretary for the purposes of this
23 subparagraph;”.

24 (2) ELIMINATION OF DEDUCTIBLE.—The first
25 sentence of section 1833(b) of such Act (42 U.S.C.

1 1395l(b)) (as amended by section 206(e)(2)) is
2 amended—

3 (A) by striking “and” before “(12)”; and

4 (B) by inserting before the period the fol-
5 lowing: “, and (13) such deductible shall not
6 apply with respect to screening and counseling
7 for osteoporosis (as defined in section
8 1861(aaa))”.

9 (d) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to services furnished on or after
11 January 1, 2002.

12 **SEC. 208. SCREENING FOR CHOLESTEROL.**

13 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
14 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
15 tion 207(a)) is amended—

16 (1) in subparagraph (Z), by striking “and” at
17 the end;

18 (2) in subparagraph (AA), by inserting “and”
19 at the end; and

20 (3) by adding at the end the following new sub-
21 paragraph:

22 “(BB) screening for cholesterol (as defined in
23 subsection (bbb)) for individuals between the ages of
24 65 and 75 that exhibit major risk factors for coro-

1 nary heart disease, including smoking, hypertension,
2 and diabetes;”.

3 (b) SERVICES DESCRIBED.—Section 1861 of such
4 Act (42 U.S.C. 1395x) (as amended by section 207(b))
5 is amended by adding at the end the following new sub-
6 section:

7 “Screening for Cholesterol

8 “(bbb) The term ‘screening for cholesterol’ means di-
9 agnostic services for cholesterol that are furnished—

10 “(1) by or under the supervision of a physician;
11 or

12 “(2) by any other health care professional who
13 is legally authorized to furnish such services under
14 State law (or the State regulatory mechanism pro-
15 vided by State law) of the State in which the serv-
16 ices are furnished, as would otherwise be covered if
17 furnished by a physician or as an incident to a phy-
18 sician’s professional service.”.

19 (c) ELIMINATION OF COST-SHARING.—

20 (1) ELIMINATION OF COINSURANCE.—Section
21 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
22 amended by section 207(c)(1)) is amended—

23 (A) by striking “and” before “(Z)”; and

24 (B) by inserting before the semicolon at
25 the end the following: “, and (AA) with respect

1 to screening for cholesterol (as defined in sec-
 2 tion 1861(bbb)), the amount paid shall be 100
 3 percent of the lesser of the actual charge for
 4 the services or the amount determined by a fee
 5 schedule established by the Secretary for the
 6 purposes of this subparagraph;”.

7 (2) ELIMINATION OF DEDUCTIBLE.—The first
 8 sentence of section 1833(b) of such Act (42 U.S.C.
 9 1395l(b)) (as amended by section 207(c)(2)) is
 10 amended—

11 (A) by striking “and” before “(13)”; and

12 (B) by inserting before the period the fol-
 13 lowing: “, and (14) such deductible shall not
 14 apply with respect to screening and counseling
 15 for osteoporosis (as defined in section
 16 1861(bbb))”.

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to services furnished on or after
 19 January 1, 2002.

20 **SEC. 209. MEDICAL NUTRITION THERAPY SERVICES FOR**
 21 **BENEFICIARIES WITH DIABETES, A CARDIO-**
 22 **VASCULAR DISEASE, OR A RENAL DISEASE.**

23 (a) COVERAGE.—Section 1861(s)(2) of the Social Se-
 24 curity Act (42 U.S.C. 1395x(s)(2)) (as amended by sec-
 25 tion 208(a)) is amended—

1 (1) in subparagraph (AA) by striking “and” at
2 the end;

3 (2) in subparagraph (BB) by inserting “and”
4 at the end; and

5 (3) by adding at the end the following new sub-
6 paragraph:

7 “(CC) medical nutrition therapy services (as de-
8 fined in subsection (ccc)(1)) in the case of a bene-
9 ficiary with diabetes, a cardiovascular disease (in-
10 cluding congestive heart failure, arteriosclerosis,
11 hyperlipidemia, hypertension, and
12 hypercholesterolemia), or a renal disease;”.

13 (b) SERVICES DESCRIBED.—Section 1861 of the So-
14 cial Security Act (42 U.S.C. 1395x) (as amended by sec-
15 tion 208(b)) is amended by adding at the end the following
16 new subsection:

17 “Medical Nutrition Therapy Services; Registered
18 Dietitian or Nutrition Professional

19 “(ccc)(1) The term ‘medical nutrition therapy serv-
20 ices’ means nutritional diagnostic, therapy, and counseling
21 services which are furnished by a registered dietitian or
22 nutrition professional (as defined in paragraph (2)) pursu-
23 ant to a referral by a physician.

1 “(2) Subject to paragraph (3), the term ‘registered
2 dietitian or nutrition professional’ means an individual
3 who—

4 “(A) holds a baccalaureate or higher degree
5 granted by a regionally accredited college or univer-
6 sity in the United States (or an equivalent foreign
7 degree) with completion of the academic require-
8 ments of a program in nutrition or dietetics, as ac-
9 credited by an appropriate national accreditation or-
10 ganization recognized by the Secretary for this pur-
11 pose;

12 “(B) has completed at least 900 hours of super-
13 vised dietetics practice under the supervision of a
14 registered dietitian or nutrition professional; and

15 “(C)(i) is licensed or certified as a dietitian or
16 nutrition professional by the State in which the serv-
17 ices are performed; or

18 “(ii) in the case of an individual in a State that
19 does not provide for such licensure or certification,
20 meets such other criteria as the Secretary estab-
21 lishes.

22 “(3) Subparagraphs (A) and (B) of paragraph (2)
23 shall not apply in the case of an individual who, as of the
24 date of enactment of this subsection, is licensed or cer-
25 tified as a dietitian or nutrition professional by the State

1 in which medical nutrition therapy services are per-
2 formed.”.

3 (c) ELIMINATION OF COINSURANCE.—Section
4 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) (as
5 amended by section 208(c)(1)) is amended—

6 (1) by striking “and” before “(AA)”; and

7 (2) by inserting before the semicolon at the end
8 the following: “, and (BB) with respect to medical
9 nutrition therapy services (as defined in section
10 1861(ccc)), the amount paid shall be 85 percent of
11 the lesser of the actual charge for the services or the
12 amount determined under the fee schedule estab-
13 lished under section 1848(b) for the same services if
14 furnished by a physician”.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section apply to services furnished on or after Janu-
17 ary 1, 2002.

18 **SEC. 210. ELIMINATION OF COST-SHARING FOR CURRENT**
19 **PREVENTIVE BENEFITS.**

20 (a) WAIVER OF COINSURANCE AND DEDUCTIBLES.—

21 (1) IN GENERAL.—Section 1834 of the Social
22 Security Act (42 U.S.C. 1395m) is amended by add-
23 ing at the end the following new subsection:

24 “(m) WAIVER OF COINSURANCE AND DEDUCTIBLE
25 FOR PREVENTIVE SERVICES.—

1 “(1) COINSURANCE.—

2 “(A) IN GENERAL.—Notwithstanding any
3 other provision of this part—

4 “(i) the Secretary shall waive any co-
5 insurance applicable to services described
6 in subparagraph (B); and

7 “(ii) with respect to payment for such
8 services, any reference to a percent that is
9 less than 100 percent shall be deemed to
10 be a reference to 100 percent.

11 “(B) SERVICES DESCRIBED.—The services
12 described in this subparagraph are the following
13 services:

14 “(i) Screening mammography (as de-
15 fined in section 1861(jj)).

16 “(ii) Screening pelvic exam (as de-
17 fined in section 1861(nn)(2)).

18 “(iii) Hepatitis B vaccine and its ad-
19 ministration (under section
20 1861(s)(10)(B)).

21 “(iv) Colorectal cancer screening test
22 (as defined in section 1861(pp)).

23 “(v) Bone mass measurement (as de-
24 fined in section 1861(rr)).

1 “(vi) Prostate cancer screening test
2 (as defined in section 1861(oo)).

3 “(vii) Diabetes outpatient self-man-
4 agement training services (as defined in
5 section 1861(qq)).

6 “(2) DEDUCTIBLE.—

7 “(A) IN GENERAL.—Notwithstanding any
8 other provision of this part, the deductible de-
9 scribed in section 1833(b) shall not apply with
10 respect to services described in subparagraph
11 (B).

12 “(B) SERVICES DESCRIBED.—The services
13 described in this subparagraph are the following
14 services:

15 “(i) Hepatitis B vaccine and its ad-
16 ministration (under section
17 1861(s)(10)(B)).

18 “(ii) Colorectal cancer screening test
19 (as defined in section 1861(pp)).

20 “(iii) Bone mass measurement (as de-
21 fined in section 1861(rr)).

22 “(iv) Prostate cancer screening test
23 (as defined in section 1861(oo)).

1 “(v) Diabetes outpatient self-manage-
2 ment training services (as defined in sec-
3 tion 1861(qq)).”.

4 (2) CONFORMING AMENDMENT.—Section
5 1833(a) of the Social Security Act (42 U.S.C.
6 1395l(a)) is amended by striking “section 1876”
7 and inserting “sections 1834 and 1876” in the mat-
8 ter preceding paragraph (1).

9 (b) EFFECTIVE DATE.—The amendments made by
10 this section shall apply to services furnished on or after
11 January 1, 2002.

12 **SEC. 211. NATIONAL FALLS PREVENTION EDUCATION AND**
13 **AWARENESS CAMPAIGN.**

14 The Secretary, in consultation with the Director of
15 the Centers for Disease Control and Prevention, shall con-
16 duct a national falls prevention and awareness campaign
17 to reduce fall-related injuries among medicare bene-
18 ficiaries.

19 **SEC. 212. PROGRAM INTEGRITY.**

20 The Secretary, in consultation with the Inspector
21 General of the Department of Health and Human Serv-
22 ices, shall integrate the benefits described in sections 201
23 through 208 with existing program integrity measures.

1 **TITLE III—MEDICARE HEALTH**
2 **EDUCATION AND RISK AP-**
3 **PRAISAL PROGRAM**

4 **SEC. 301. MEDICARE HEALTH EDUCATION AND RISK AP-**
5 **PRAISAL PROGRAM.**

6 Title XVIII of the Social Security Act (42 U.S.C.
7 1395 et seq.) is amended by adding at the end the fol-
8 lowing new section:

9 “MEDICARE HEALTH EDUCATION AND RISK APPRAISAL
10 PROGRAM

11 “SEC. 1897. (a) ESTABLISHMENT.—The Secretary,
12 in consultation with the Director of the Centers for Dis-
13 ease Control and Prevention, the Administrator of the
14 Agency for Health Care Policy and Research, and the Ad-
15 ministrator of the Health Care Financing Administration,
16 shall establish a health education and risk appraisal pro-
17 gram to inform the target individuals described in sub-
18 section (b) of the major behavioral risk factors described
19 in subsection (c) through the self-assessment described in
20 subsection (d) and shall conduct the periodic followup de-
21 scribed in subsection (e).

22 “(b) TARGET INDIVIDUALS.—The target individuals
23 described in this subsection are the following:

24 “(1) MEDICARE BENEFICIARIES.—Individuals
25 that are beneficiaries under this title.

1 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
2 AND 64.—Individuals between the ages of 50 and 64.

3 “(c) MAJOR BEHAVIORAL RISK FACTORS.—The
4 major behavioral risk factors described in this subsection
5 include—

6 “(1) the lack of proper nutrition;

7 “(2) the use of alcohol;

8 “(3) the lack of regular exercise;

9 “(4) the use of tobacco;

10 “(5) depression; and

11 “(6) other risk factors identified by the Sec-
12 retary.

13 “(d) SELF-ASSESSMENT.—

14 “(1) IN GENERAL.—The self-assessment de-
15 scribed in this subsection is a form delivered by the
16 Secretary to each target individual that—

17 “(A) includes questions regarding major
18 behavioral risk factors;

19 “(B) requests that such individual answer
20 the questions and return the form to the Sec-
21 retary; and

22 “(C) is then assessed using—

23 “(i) knowledge coupling computer
24 software that assesses overall health risks

1 and then provides options for management
2 of identified risk factors;

3 “(ii) nurse hotlines; and

4 “(iii) case managers as the Secretary
5 determines appropriate.

6 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
7 AND 64.—With respect to the target individuals de-
8 scribed in subsection (b)(2), the Secretary shall co-
9 ordinate the delivery of the self-assessment form
10 with the issuance of the statement described in sec-
11 tion 1143(c)(2).

12 “(e) PERIODIC FOLLOWUP.—

13 “(1) MEDICARE BENEFICIARIES.—Not less fre-
14 quently than once every 2 years, the Secretary shall
15 conduct periodic followup appraisals with respect to
16 the target individuals described in subsection (b)(1)
17 to reduce major behavioral risk factors described in
18 subsection (c)—

19 “(A) by providing such individuals with—

20 “(i) information regarding the results
21 of the self-administered risk appraisal;

22 “(ii) recommendations regarding be-
23 havior modifications based on such ap-
24 praisal; and

1 “(iii) information regarding any need
2 for further assessment or treatment; and

3 “(B) by providing the information de-
4 scribed in subparagraph (A) to the provider
5 designated by such individual to receive such in-
6 formation.

7 “(2) INDIVIDUALS BETWEEN THE AGES OF 50
8 AND 64.—The Secretary shall conduct such periodic
9 followup appraisals with respect to the target indi-
10 viduals described in subsection (b)(2) as the Sec-
11 retary determines appropriate.”.

12 **TITLE IV—DISEASE SELF-MAN-**
13 **AGEMENT DEMONSTRATION**
14 **PROJECTS**

15 **SEC. 401. DISEASE SELF-MANAGEMENT DEMONSTRATION**
16 **PROJECTS.**

17 (a) DEMONSTRATION PROJECTS.—

18 (1) IN GENERAL.—The Secretary, acting
19 through the Administrator of the Health Care Fi-
20 nancing Administration, shall conduct demonstration
21 projects for the purpose of promoting disease self-
22 management for conditions identified by the working
23 group established under paragraph (2) for target in-
24 dividuals (as defined in paragraph (3)).

1 (2) DISEASE SELF-MANAGEMENT WORKING
2 GROUP.—

3 (A) ESTABLISHMENT.—There is estab-
4 lished within the Department of Health and
5 Human Services a Disease Self-Management
6 Working Group.

7 (B) COMPOSITION.—The Disease Self-
8 Management Working Group established under
9 subparagraph (A) shall be composed of 4 mem-
10 bers as follows:

11 (i) The Administrator of the Health
12 Care Financing Administration.

13 (ii) The Director of the Centers for
14 Disease Control and Prevention.

15 (iii) The Administrator of the Agency
16 for Health Care Policy and Research.

17 (iv) The Director of the Administra-
18 tion on Aging.

19 (C) GENERAL POLICIES AND CRITERIA.—
20 The Disease Self-Management Working Group
21 established under paragraph (1) shall establish
22 general policies and criteria with respect to the
23 functions of the Secretary under this section
24 including—

1 (i) the identification of conditions for
2 which a demonstration project may be im-
3 plemented;

4 (ii) the prioritization of the conditions
5 identified under clause (i) based on poten-
6 tial of self-management of such condition
7 to be medically effective and for such self-
8 management to be a cost-effective benefit
9 or cost-saving benefit, as those terms are
10 defined in section 3 of this Act;

11 (iii) the identification of target indi-
12 viduals;

13 (iv) the development of procedures for
14 selecting areas in which a demonstration
15 project may be implemented; and

16 (v) such other matters as are rec-
17 ommended by the Disease Self-Manage-
18 ment Working Group and approved by the
19 Secretary.

20 (3) TARGET INDIVIDUAL DEFINED.—In this
21 section, the term “target individual” means an indi-
22 vidual that is at risk for or has a condition identified
23 by the working group described under paragraph (2)
24 and is eligible for benefits under the fee-for-service
25 program under parts A and B of title XVIII of the

1 Social Security Act (42 U.S.C. 1395c et seq.; 1395j
2 et seq.) or is enrolled under the Medicare+Choice
3 program under part C of title XVIII of such Act (42
4 U.S.C. 1395w-21 et seq.).

5 (b) NUMBER, PROJECT AREAS, AND DURATION.—

6 (1) NUMBER.—Not later than 2 years after the
7 date of enactment of this Act, the Secretary shall
8 implement a series of demonstration projects.

9 (2) PROJECT AREAS.—The Secretary, acting
10 through the Administrator of the Health Care Fi-
11 nancing Administration, shall implement the dem-
12 onstration projects described in paragraph (1) in
13 urban, suburban, and rural areas.

14 (3) DURATION.—The demonstration projects
15 under this section shall be conducted for a period of
16 3 years, beginning on the date on which the Sec-
17 retary implements the initial demonstration project.

18 (c) REPORTS TO CONGRESS.—

19 (1) ANNUAL REPORTS.—

20 (A) IN GENERAL.—Not later than 1 year
21 after the Secretary implements the initial dem-
22 onstration project under this section, and bian-
23 nually thereafter, the Secretary shall submit to
24 Congress a report regarding the demonstration
25 projects conducted under this section.

1 (B) CONTENTS OF REPORT.—The report
2 in subparagraph (A) shall include the following:

3 (i) A description of the demonstration
4 projects conducted under this section.

5 (ii) An evaluation of—

6 (I) whether each benefit provided
7 under the demonstration project is a
8 cost-effective benefit or a cost-saving
9 benefit;

10 (II) the level of the disease self-
11 management attained by target indi-
12 viduals under the demonstration
13 projects; and

14 (III) the satisfaction of target in-
15 dividuals under the demonstration
16 project.

17 (iii) Any other information regarding
18 the demonstration projects conducted
19 under this section that the Secretary deter-
20 mines to be appropriate.

21 (2) FINAL REPORT.—Not later than 1 year
22 after the conclusion of the demonstration projects
23 under this section, the Secretary shall submit a final
24 report to Congress on the demonstration projects
25 conducted under this section containing the rec-

ommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis, together with such recommendations for legislation and administrative action as the Secretary considers appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed \$30,000,000 for the costs of carrying out the demonstration projects under this section, establishing the Disease Self-Management Working Group under subsection (a)(2), and submitting the reports to Congress under subsection (c).

TITLE V—STUDIES AND REPORTS ADVANCING ORIGINAL RESEARCH IN THE FIELD OF DISEASE PREVENTION AND THE ELDERLY

SEC. 501. MEDPAC BIENNIAL REPORT.

(a) IN GENERAL.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (C), by striking “and” at the end;

1 (B) in subparagraph (D), by striking the
2 period and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(E) by not later than January 1, 2002,
6 and biannually thereafter, submit the report to
7 Congress described in paragraph (7).”; and

8 (2) by adding at the end the following new
9 paragraph:

10 “(7) EVALUATION OF ACTUARIAL EQUIVALENCE
11 OF MEDICARE AND PRIVATE SECTOR BENEFIT PACK-
12 AGES.—

13 “(A) EVALUATION.—The Commission
14 shall—

15 “(i) evaluate the benefit package of-
16 fered under the medicare program under
17 this title; and

18 “(ii) determine the degree to which
19 such benefit package is actuarially equiva-
20 lent to that offered by health benefit pro-
21 grams available in the private sector to in-
22 dividuals over age 65.

23 “(B) REPORT.—The Commission shall
24 submit a report to Congress that shall
25 contain—

1 “(i) a detailed statement of the find-
2 ings and conclusions of the Commission re-
3 garding the evaluation conducted under
4 subparagraph (A);

5 “(ii) the recommendations of the
6 Commission regarding changes in the ben-
7 efit package offered under the medicare
8 program under this title that would keep
9 the program modern and competitive in re-
10 lation to health benefit programs available
11 in the private sector; and

12 “(iii) the recommendations of the
13 Commission for such legislation and ad-
14 ministrative actions as it considers appro-
15 priate.”.

16 (b) **EFFECTIVE DATE.**—The amendments made by
17 this section shall take effect on the date of enactment of
18 this Act.

19 **SEC. 502. NATIONAL INSTITUTE ON AGING STUDY AND RE-**
20 **PORT.**

21 (a) **STUDIES.**—The Director of the National Institute
22 on Aging shall conduct 1 or more studies focusing on ways
23 to—

24 (1) improve quality of life for the elderly;

1 (2) develop better ways to prevent or delay the
2 onset of age-related functional decline and disease
3 and disability among the elderly; and

4 (3) develop means of assessing the long-term
5 development of cost-effective benefits and cost-sav-
6 ings benefits for health promotion and disease pre-
7 vention among the elderly.

8 (b) REPORT.—Not later than January 1, 2006, the
9 Director of the National Institute on Aging shall submit
10 a report to the Secretary regarding each study conducted
11 under subsection (a) and containing a detailed statement
12 of research findings and conclusions that are scientifically
13 valid and are demonstrated to prevent or delay the onset
14 of chronic illness or disability among the elderly.

15 (c) TRANSMISSION TO INSTITUTE OF MEDICINE.—
16 Upon receipt of each report described in subsection (b),
17 the Secretary shall transmit such report to the Institute
18 of Medicine of the National Academy of Sciences for con-
19 sideration in its effort to conduct the comprehensive study
20 of current literature and best practices in the field of
21 health promotion and disease prevention among the medi-
22 care beneficiaries described in section 503.

23 (d) AUTHORIZATION OF APPROPRIATIONS.—

24 (1) IN GENERAL.—There are authorized to be
25 appropriated \$100,000,000 for fiscal years 2001

1 through 2006 to carry out the purposes of this sec-
2 tion.

3 (2) AVAILABILITY.—Any sums appropriated
4 under the authorization contained in this subsection
5 shall remain available, without fiscal year limitation,
6 until September 30, 2005.

7 **SEC. 503. INSTITUTE OF MEDICINE 5-YEAR MEDICARE PRE-**
8 **VENTION BENEFIT STUDY AND REPORT.**

9 (a) STUDY.—

10 (1) IN GENERAL.—The Secretary shall contract
11 with the Institute of Medicine of the National Acad-
12 emy of Sciences to conduct a comprehensive study of
13 current literature and best practices in the field of
14 health promotion and disease prevention among
15 medicare beneficiaries including the issues described
16 in paragraph (2) and to submit the report described
17 in subsection (b).

18 (2) ISSUES STUDIED.—The study required
19 under paragraph (1) shall include an assessment
20 of—

21 (A) whether each covered benefit is—

22 (i) medically effective; and

23 (ii) a cost-effective benefit or a cost-
24 saving benefit;

1 (B) utilization of covered benefits (includ-
2 ing any barriers to or incentives to increase uti-
3 lization); and

4 (C) quality of life issues associated with
5 both health promotion and disease prevention
6 benefits covered under the medicare program
7 and those that are not covered under such pro-
8 gram that would affect all medicare bene-
9 ficiaries.

10 (b) REPORT.—

11 (1) IN GENERAL.—Not later than 5 years after
12 the date of enactment of this section, and every fifth
13 year thereafter, the Institute of Medicine of the Na-
14 tional Academy of Sciences shall submit to the
15 President a report that contains a detailed state-
16 ment of the findings and conclusions of the study
17 conducted under subsection (a) and the rec-
18 ommendations for legislation described in paragraph
19 (2).

20 (2) RECOMMENDATIONS FOR LEGISLATION.—
21 The Institute of Medicine of the National Academy
22 of Sciences, in consultation with the Partnership for
23 Prevention, shall develop recommendations in legis-
24 lative form that—

1 (A) prioritize the preventive benefits under
2 the medicare program; and

3 (B) modify preventive benefits offered
4 under the medicare program based on the study
5 conducted under subsection (a).

6 (c) TRANSMISSION TO CONGRESS.—

7 (1) IN GENERAL.—On the day on which the re-
8 port described in subsection (b) is submitted to the
9 President, the President shall transmit the report
10 and recommendations in legislative form described in
11 subsection (b)(2) to Congress.

12 (2) DELIVERY.—Copies of the report and rec-
13 ommendations in legislative form required to be
14 transmitted to Congress under paragraph (1) shall
15 be delivered—

16 (A) to both Houses of Congress on the
17 same day;

18 (B) to the Clerk of the House of Rep-
19 resentatives if the House is not in session; and

20 (C) to the Secretary of the Senate if the
21 Senate is not in session.

22 **SEC. 504. FAST-TRACK CONSIDERATION OF PREVENTION**
23 **BENEFIT LEGISLATION.**

24 (a) RULES OF HOUSE OF REPRESENTATIVES AND
25 SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 503(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such re-

port shall be introduced as a bill (by request)
in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In
the House of Representatives, by the Ma-
jority Leader, for himself and the Minority
Leader, or by Members of the House of
Representatives designated by the Majority
Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the
Majority Leader, for himself and the Mi-
nority Leader, or by Members of the Sen-
ate designated by the Majority Leader and
Minority Leader.

(B) SPECIAL RULE.—If either House of
Congress is not in session on the day on which
such recommendations in legislative form are
transmitted, the recommendations in legislative
form shall be introduced as a bill in that House
of Congress, as provided in subparagraph (A),
on the first day thereafter on which that House
of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by
the presiding officers of the respective Houses to the
appropriate committee, or, in the case of a bill con-
taining provisions within the jurisdiction of 2 or

1 more committees, jointly to such committees for con-
2 sideration of those provisions within their respective
3 jurisdictions.

4 (c) CONSIDERATION.—After the recommendations in
5 legislative form have been introduced as a bill and referred
6 under subsection (b), such implementing bill shall be con-
7 sidered in the same manner as an implementing bill is con-
8 sidered under subsections (d), (e), (f), and (g) of section
9 151 of the Trade Act of 1974 (19 U.S.C. 2191).

10 (d) IMPLEMENTING BILL DEFINED.—In this section,
11 the term “implementing bill” means only the recommenda-
12 tions in legislative form of the Institute of Medicine of the
13 National Academy of Sciences described in section
14 503(b)(2), transmitted by the President to the House of
15 Representatives and the Senate under subsection 503(c),
16 and introduced and referred as provided in subsection (b)
17 as a bill of either House of Congress.

18 (e) COUNTING OF DAYS.—For purposes of this sec-
19 tion, any period of days referred to in section 151 of the
20 Trade Act of 1974 shall be computed by excluding—

21 (1) the days on which either House of Congress
22 is not in session because of an adjournment of more
23 than 3 days to a day certain or an adjournment of
24 Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

TITLE VI—CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS

SEC. 601. CLINICAL DEPRESSION SCREENING DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Care Financing Administration, shall conduct demonstration projects for the purpose of evaluating the efficacy of providing annual screenings for clinical depression as a benefit under the medicare program.

(2) ANNUAL SCREENING FOR CLINICAL DEPRESSION DEFINED.—For purposes of this section, the term “annual screening for clinical depression” means the following, conducted with respect to a medicare beneficiary no more frequently than annually:

(A) A self-administered written screening test (using an instrument to be chosen and distributed by the Secretary at least 3 months before date that benefits are first provided under

1 demonstration projects under this section)
2 which asks questions to establish a beneficiary's
3 risk of clinical depression.

4 (B) After administering such a test, a con-
5 sultation as a followup to such a test with a
6 physician, nurse practitioner, or mental health
7 professional licensed under State law to deter-
8 mine whether the beneficiary has or is at high
9 risk of developing clinical depression.

10 (C) If the health care professional deter-
11 mines that the beneficiary is at high risk, a re-
12 ferral of the beneficiary to a physician or men-
13 tal health professional for a full diagnostic eval-
14 uation.

15 (3) PAYMENT LEVEL.—The reimbursement
16 level for health care professionals will be set by the
17 Secretary in accordance with generally accepted pay-
18 ment levels for the type of service involved and shall
19 not require payment of any deductibles or coinsur-
20 ance.

21 (b) NUMBER, PROJECT AREAS, AND DURATION.—

22 (1) NUMBER.—Not later than 1 year after the
23 date of enactment of this Act, the Secretary shall
24 implement no fewer than 6, and no more than 10,
25 demonstration projects under this section.

1 (2) PROJECT AREAS.—The Secretary, acting
2 through the Administrator of the Health Care Fi-
3 nancing Administration, shall implement the dem-
4 onstration projects described in paragraph (1) in
5 urban, suburban, and rural areas. Areas are to be
6 chosen in a manner that fosters geographic diversity
7 and a mix of screening sites (including doctors' of-
8 fices, mental health clinics, and nursing homes) and
9 that gives preference to areas with a high concentra-
10 tion of medicare beneficiaries.

11 (3) DURATION.—The demonstration projects
12 under this section shall be conducted for a period of
13 3 years, beginning on the date on which the Sec-
14 retary implements the initial demonstration project.

15 (c) REPORTS TO CONGRESS.—

16 (1) ANNUAL REPORTS.—

17 (A) IN GENERAL.—Not later than 1 year
18 after the Secretary implements the initial dem-
19 onstration project under this section, and bian-
20 nually thereafter, the Secretary shall submit to
21 Congress a report regarding the demonstration
22 projects conducted under this section.

23 (B) CONTENTS OF REPORT.—The report
24 in subparagraph (A) shall include the following:

1 (i) A description of the demonstration
2 projects conducted under this section.

3 (ii) An evaluation of—

4 (I) whether each benefit provided
5 under the demonstration project is a
6 cost-effective benefit or a cost-saving
7 benefit; and

8 (II) the satisfaction of medicare
9 beneficiaries under the demonstration
10 project.

11 (iii) Any other information regarding
12 the demonstration projects conducted
13 under this section that the Secretary deter-
14 mines to be appropriate.

15 (2) FINAL REPORT.—Not later than 1 year
16 after the conclusion of the demonstration projects
17 under this section, the Secretary shall submit a final
18 report to Congress on the demonstration projects
19 conducted under this section containing the rec-
20 ommendations of the Secretary regarding whether to
21 conduct the demonstration projects on a permanent
22 basis, together with such recommendations for legis-
23 lation and administrative action as the Secretary
24 considers appropriate.

1 (d) FUNDING.—The Secretary shall provide for the
2 transfer from the Federal Hospital Insurance Trust Fund
3 under section 1817 of the Social Security Act (42 U.S.C.
4 1395i) an amount not to exceed \$30,000,000 for the costs
5 of carrying out the demonstration projects under this sec-
6 tion and submitting the reports to Congress under sub-
7 section (c).

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